## NOTICE OF INDEPENDENT REVIEW DECISION

Date: July 9, 2003

RE: MDR Tracking #: IRO Certificate #:	M2-03-1171-01 5242
has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.	
has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.	
The independent review was performed by an Anesthesia and Pain Management physician reviewer who is board certified in Anesthesia and Pain Management. The Anesthesia and Pain Management reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.	
Clinical History	
underwent surgery in 1995 of She still has complaints of p	ck in I have a very limited amount of notes at this time. She on one note and another note states she underwent surgery in 1999. ain across the back and down the left leg. She underwent 2 recent the no improvement of her pain.
Requested Service(s)	
Repeat MRI of the lumbar sp	ine with and without contrast
<b>Decision</b>	
I agree with the insurance carrier that the services requested are not medically necessary.	

## done showing discogenic abnormalities. There is no date of this MRI scanning. It is important to know whether this scan followed the surgery itself. There is also no information that there are any new neurological or pain problems.

**Rationale/Basis for Decision** 

The claimant was injured back in \_\_\_ and underwent surgery. I have no information discussing when she actually had surgery and what surgery she had. It was also noted there was an MRI

The most recent note from the requesting physician says no neurological deficits. In conclusion as there is not significant information on the claimant's date of surgery, if the MRI he discussed was post surgery and in absence of any new symptomatology or physical findings, repeat scanning is denied.

## YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 (ten) days of your receipt of this decision (20 Tex. Admin. Code 142.5(c)).

**If disputing other prospective medical necessity (preauthorization) decisions** a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Workers' Compensation Commission, P.O. Box 40669, Austin, Texas, 78704-0012. A copy of this decision should be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute (Commission Rule 133.308 (t)(2)).

This decision by the IRO is deemed to be a TWCC decision and order.